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HEALTH, MORBIDITY AND MORTALITY

(Chapter VIII of the draft programme of action of the Conference)

Text submitted by the Vice-Chairman, Mr. Nicolaas Biegman (Netherlands) (Working Group II), on the basis of negotiations held on document A/CONF.171/PC/5

Chapter VIII

HEALTH, MORBIDITY AND MORTALITY

A. Primary health care and the health-care sector

Basis for action

8.1. One of the main achievements of the twentieth century has been the unprecedented increase in human longevity. In the past half century, expectation of life at birth in the world as a whole has increased by about 20 years, and the risk of dying in the first year of life has been reduced by nearly two thirds. Nevertheless, these achievements fall short of the much greater improvements that had been anticipated in the World Population Plan of Action and the Declaration of Alma Ata, adopted by the International Conference on Primary Health Care in 1978. There remain entire national populations and sizeable population groups within many countries that are still subject to very high rates of morbidity and mortality. Differences linked to socio-economic status or ethnicity are often substantial. In many countries with economies in transition, the mortality rate has considerably increased as a result of deaths caused by accidents and violence.

8.2. The increases in life expectancy recorded in most regions of the world reflect significant gains in public health and in access to primary health-care services. Notable achievements include the vaccination of about 80 per cent of the children in the world and the widespread use of low-cost treatments, such as oral rehydration therapy, to ensure that more children survive. Yet these achievements have not been realized in all countries, and preventable or treatable illnesses are still the leading killers of young children. Moreover, large segments of many populations continue to lack access to clean water and sanitation facilities, are forced to live in congested conditions and lack adequate nutrition. Large numbers of people remain at continued risk of infectious and parasitic and water-borne diseases, such as tuberculosis, malaria and schistosomiasis. In addition, the health effects of environmental degradation and exposure to hazardous substances in the workplace are increasingly a cause of concern in many countries. Similarly, the growing consumption of tobacco, alcohol and drugs will precipitate a marked increase in costly chronic diseases among working age and elderly people. The impact of reductions in expenditures for health and other social services which have taken place in many countries as a result of public-sector retrenchment, misallocation of available health resources, structural adjustment and the transition to market economies has preempted significant changes in lifestyles, livelihoods and consumption patterns and is also a factor in increasing morbidity and mortality. Although economic reforms are essential to sustained economic growth, it is equally essential that the design and implementation of structural adjustment programmes incorporate the social dimension.

Objectives

8.3. The objectives are:

(a) To increase the accessibility, availability, acceptability and affordability of health care services and facilities to all people in accordance with national commitments to provide access to basic health care for all;

(b) To increase the healthy life-span and improve the quality of life of all people, and to reduce disparities in life expectancy between and within countries.

Actions

8.4. All countries should make access to basic health care and health promotion the central strategies for reducing mortality and morbidity. Sufficient resources should be assigned so that primary health services attain full coverage of the population. Governments should strengthen health and nutrition information, education and communication activities so as to enable people to increase their control over and improve their health. Governments should provide the necessary backup facilities to meet the demand created.

8.5. In keeping with the Declaration of Alma Ata, all countries should reduce mortality and morbidity and seek to make primary health care, including reproductive health care, available universally by the end of the current decade. [Countries should aim to achieve by 2005 a life expectancy at birth greater than 70 years and by 2015 a life expectancy at birth greater than 75 years. Countries with the highest levels of mortality should aim to achieve by 2005 a life expectancy at birth greater than 65 years and by 2015 a life expectancy at birth greater than 70 years.] Efforts to ensure a longer and healthier life for all should emphasize the reduction of morbidity and mortality differentials between males and females as well as among geographical regions, social classes and indigenous and ethnic groups.

8.6. The role of women as primary custodians of family health should be recognized and supported. Access to basic health care, expanded health education, the availability of simple cost-effective remedies, and the reappraisal of primary health-care services, including [reproductive health care services] to facilitate proper use of women's time, should be provided.

8.7. Governments should ensure community participation in health policy planning, especially with respect to the long-term care of the elderly, those with disabilities and those infected with HIV and other endemic diseases. Such participation should also be promoted in child-survival and maternal health programmes, breast-feeding support programmes, programmes for the early detection and treatment of cancer of the reproductive system, and programmes for the prevention of HIV infection and other sexually transmitted diseases.

8.7 bis. All countries should re-examine training curricula and the delegation of responsibilities within the health-care delivery system in order to reduce frequent, unnecessary and costly reliance on physicians and on secondary- and tertiary-care facilities, while maintaining effective referral services. Access

to health care services for all people and especially for the most underserved and vulnerable groups must be ensured. Governments should seek to make basic health care services more sustainable financially, while ensuring equitable access, by integrating [sexual and reproductive] health services, including maternal and child health and family planning services, and by making appropriate use of community-based services, social marketing and cost-recovery schemes with the aim of increasing the range and quality of services available. The involvement of users and the community in the financial management of health care services should be promoted.

8.7 ter. Through technology transfer, developing countries should be assisted in building their capacity to produce generic drugs for the domestic market and to ensure the wide availability and accessibility of such drugs. To meet the substantial increase in demand for vaccines, antibiotics, and other commodities over the next decade and beyond, the international community should strengthen global, regional and local mechanisms for the production, quality control, and procurement of those items, where feasible, in developing countries. The international community should facilitate regional cooperation in the manufacture, quality control and distribution of vaccines.

8.8. All countries should give priority to measures that improve the quality of life and health by ensuring a safe and sanitary living environment for all population groups through measures aimed at avoiding crowded housing conditions, reducing air pollution, ensuring access to clean water and sanitation, improving waste management, and increasing the safety of the workplace. Special attention should be given to the living conditions of the poor and disadvantaged in urban and rural areas. The impact of environmental problems on health, particularly that of vulnerable groups, should be monitored by Governments on a regular basis.

8.8 bis. Reform of the health sector and health policy, including the rational allocation of resources, should be promoted in order to achieve the stated objectives. All Governments should examine ways to maximize the cost-effectiveness of health programmes in order to achieve increased life expectancy, reduce morbidity and mortality and ensure access to basic health care services for all people.

B. Child survival and health

Basis for action

8.9. Important progress has been made in reducing infant and child mortality rates everywhere. Improvements in the survival of children have been the main component of the overall increase in average life expectancy in the world over the past century, first in the developed countries and over the past 50 years in the developing countries. The number of infant deaths (i.e., of children under age 1) per 1,000 live births at the world level declined from 92 in 1970-1975 to about 62 in 1990-1995. For developed regions, the decline was from 22 to 12 infant deaths per 1,000 births, and for developing countries from 105 to 69 infant deaths per 1,000 births. Improvements have been slower in sub-Saharan Africa and in some Asian countries where, during 1990-1995, more than one in

every 10 children born alive will die before their first birthday. The mortality of children under age 5 exhibits significant variations between and within regions and countries. Indigenous peoples generally have higher infant and child mortality rates than the national norm. Poverty, malnutrition, a decline in breast-feeding, inadequacy or lack of sanitation and of health facilities are all factors associated with high infant and child mortality. In some countries, civil unrest and wars have also had major negative impacts on child survival. Unwanted births, child neglect and abuse are also factors contributing to the rise in child mortality. In addition, HIV infection can be transmitted from mother to child before or during childbirth, and young children whose mothers die are at a very high risk of dying themselves at a young age.

8.10. The World Summit for Children, held in 1990, adopted a set of goals for children and development up to the year 2000, including a reduction in infant and under-5 child mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less. These goals are based on the accomplishments of child survival programmes during the 1980s, which demonstrate not only that effective low-cost technologies are available but that they can be delivered efficiently to large populations. However, the morbidity and mortality reductions achieved through extraordinary measures in the 1980s are in danger of being eroded if the broad-based health delivery systems established during the decade are not institutionalized and sustained.

8.11. Child survival is closely linked to the timing, spacing and number of births and to the reproductive health of mothers. Early, late, numerous and closely spaced pregnancies are major contributors to high infant and child mortality and morbidity rates, especially where health-care facilities are scarce. Where infant mortality remains high, couples often have more children than they otherwise would to ensure that a desired number survive.

Objectives

8.12. The objectives are:

(a) To promote child health and survival and to reduce disparities between and within developed and developing countries as quickly as possible, with particular attention to eliminating the pattern of excess and preventable mortality among girl infants and children;

(b) To improve the health and nutritional status of infants and children;

(c) To promote breast-feeding as a child-survival strategy.

Actions

8.13. Over the next 20 years, through international cooperation and national programmes, the gap between average infant and child mortality rates in the developed and the developing regions of the world should be substantially narrowed, and disparities within countries, those between geographical regions, ethnic or cultural groups, and socio-economic groups should be eliminated. Countries with indigenous people should achieve infant and under-5 mortality levels among their indigenous people that are the same as those of the general

population. [Countries should strive to reduce their infant and under-5 mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less, by the year 2000, with appropriate adaptation to the particular situation of each country. By 2005, countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 and an under-5 mortality rate below 60 deaths per 1,000 births. By 2015 all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-5 mortality rate below 45 per 1,000. Countries that achieve these levels earlier should strive to lower them further.]

8.14. All Governments should assess the underlying causes of high child mortality and should, within the framework of primary health care, extend integrated reproductive health care and child health services, including safe motherhood, child survival programmes and family planning services, to all the population and particularly to the most vulnerable and underserved groups. Such services should include prenatal care and counselling, with special emphasis on high-risk pregnancies and the prevention of sexually transmitted diseases and HIV infection; adequate delivery assistance; and neonatal care, including exclusive breast-feeding, information on optimal breast-feeding and on proper weaning practices, and the provision of micronutrient supplementation, where appropriate. Interventions to reduce the incidence of low-birth weight and other nutritional deficiencies, such as anaemia, should include the promotion of maternal nutrition through information, education and counselling and the promotion of longer intervals between births. All countries should give priority to efforts to reduce the major childhood diseases, particularly infectious and parasitic diseases, and to prevent malnutrition among children, especially the girl child, through measures aimed at eradicating poverty and ensuring that all children live in a sanitary environment and by disseminating information on hygiene and nutrition. It is also important to provide parents with information and education about child care, including the use of mental and physical stimulation.

8.14 bis. In order for infants and children to receive the best nutrition and for specific protection against a range of diseases, breast-feeding should be protected, promoted and supported. By means of legal, economic, practical and emotional support, mothers should be enabled to breast-feed their infants exclusively for 4-6 months, without food or drink supplementation and to continue breast-feeding infants with appropriate and adequate complementary food up to the age of 2 years or beyond. To achieve these goals, Governments should promote public information on the benefits of breast-feeding; health personnel should receive training on the management of breast-feeding; and countries should examine ways and means to implement fully the WHO International Code of Marketing of Breast Milk Substitutes.

C. Women's health and safe motherhood

Basis for action

8.15. Complications related to pregnancy and childbirth are among the leading causes of mortality for women of reproductive age in many parts of the

developing world. At the global level, it has been estimated that about half a million women die each year of pregnancy-related causes, 99 per cent of them in developing countries. The gap in maternal mortality between developed and developing regions is wide: in 1988, they ranged from over 700 per 100,000 live births in the least developed countries to about 26 per 100,000 live births in the developed regions. Rates of 1,000 or more maternal deaths per 100,000 live births have been reported in several rural areas of Africa, giving women with many pregnancies a high lifetime risk of death during their reproductive years. According to the World Health Organization (WHO), the lifetime risk of dying from pregnancy or childbirth-related causes is 1 in 20 in developing countries, compared to 1 in 10,000 in some developed countries. The age at which women begin or stop child-bearing, the interval between each birth, the total number of lifetime pregnancies and the socio-cultural and economic circumstances in which women live all influence maternal morbidity and mortality. At present, approximately 90 per cent of the countries of the world, representing 96 per cent of the world's population, have policies that permit abortion to save the life of a woman. However, a significant proportion of the abortions carried out are self-induced or otherwise unsafe, leading to a large fraction of maternal deaths or to permanent injury to the women involved. Maternal deaths have very serious consequences within the family, given the crucial role of the mother for her children's health and welfare. The death of the mother increases the risk to the survival of her young children, especially if the family is not able to provide a substitute for the maternal role. Greater attention to the reproductive health needs of female adolescents and young women could prevent the major share of maternal morbidity and mortality through prevention of unwanted pregnancies and any subsequent poorly managed abortion. Safe Motherhood, a notion which does not include the [promotion] of abortion as a method of family planning, has been accepted in many countries as a strategy to reduce maternal morbidity and mortality.

Objective

8.16. The objectives are:

(a) To promote women's health and safe motherhood; to achieve a rapid and substantial reduction in maternal morbidity and mortality and reduce the differences observed between developing and developed countries and within countries. On the basis of a commitment to women's health and well-being, to reduce greatly the number of deaths and morbidity from unsafe abortion;

(b) To improve the health and nutritional status of women, especially of pregnant and nursing women.

Actions

8.17. Countries should strive to effect significant reductions in maternal mortality by the year 2015; [a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. The realization of these goals will have different implications for countries with different 1990 levels of maternal mortality. Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate

below 60 per 100,000 live births. Countries with the highest levels of mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births.] However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed.

8.18. All countries, with the support of all sections of the international community, must expand the provision of maternal health services in the context of primary health care. These services, based on the concept of informed choice, should include education on safe motherhood, prenatal care that is focused and effective, maternal nutrition programmes, adequate delivery assistance that avoids excessive recourse to caesarean sections and provides for obstetric emergencies; referral services for pregnancy, childbirth and abortion complications; post-natal care and family planning. All births should be assisted by trained persons, preferably nurses and midwives, but at least by trained birth attendants. The underlying causes of maternal morbidity and mortality should be identified, and attention should be given to the development of strategies to overcome them and for adequate evaluation and monitoring mechanisms to assess the progress being made in reducing maternal mortality and morbidity and to enhance the effectiveness of ongoing programmes. Programmes and education to engage men's support for maternal health and safe motherhood should be developed.

8.19. All countries, especially developing countries, with the support of the international community, should aim at further reductions in maternal mortality through measures to prevent, detect and manage high-risk pregnancies and births, particularly those to adolescents and late-parity women.

8.20. All countries should design and implement special programmes to address the nutritional needs of women of child-bearing age, especially those who are pregnant or breast-feeding, and should give particular attention to the prevention and management of nutritional anaemia and iodine-deficiency disorders. Priority should be accorded to improving the nutritional and health status of young women through education and training as part of maternal health and safe motherhood programmes. Adolescent females and males should be provided with information, education and counselling to help them delay early marriage and unions, premature sexual activity and first pregnancy.

8.21. All Governments, intergovernmental organizations and relevant non-governmental organizations are urged to deal openly and forthrightly with [unsafe abortion] as a major public health concern. Particular efforts should be made to obtain objective and reliable information on the policies on, incidence of and consequences of abortion in every country. Unwanted pregnancies should be prevented through sexual health education and through expanded and improved family planning services, including proper counselling to reduce the rate of abortion. Governments are urged to assess the health and social impact of induced abortion, to address the situations that cause women to have recourse to abortion and to provide adequate medical care and counselling. [Governments are urged to evaluate and review laws and policies on abortion so that they take into account the commitment to women's health and well-being in

accordance with local situations, rather than relying on criminal codes or punitive measures. Although the main objective of public policy is to prevent unwanted pregnancies and reduce the rate of abortion, women should have ready access to quality health care services that include reliable information, counselling and medical care to enable them to terminate pregnancies in those cases where it is allowed by law, if they so decide, and that provide for the management of complications and sequelae of unsafe abortion.] Post-abortion counselling, education and family planning services should be offered promptly so as to prevent repeat abortions.

8.22. Programmes to reduce maternal morbidity and mortality should include information and [reproductive health services], including family planning services. In order to reduce high-risk pregnancies, maternal health and safe motherhood programmes should include counselling and family planning information.

8.23. All countries, as a matter of some urgency, need to seek changes in high-risk sexual behaviour and devise strategies to ensure that men share responsibility for sexual and reproductive health, including family planning, and for preventing and controlling sexually transmitted diseases, HIV infection and AIDS.

D. Human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS)

Basis for action

8.24. The AIDS pandemic is a major concern in both developed and developing countries. WHO estimates that the cumulative number of AIDS cases in the world amounted to 2.5 million persons by mid 1993 and that over 14 million people had been infected with HIV since the pandemic began, a number that is projected to rise to between 30 million and 40 million by the end of the decade, if effective prevention strategies are not pursued. As of mid 1993, about four fifths of all persons ever infected with HIV lived in developing countries where the infection was being transmitted mainly through heterosexual intercourse and the number of new cases was rising most rapidly among women. As a consequence, a growing number of children are becoming orphans, themselves at high risk of illness and death. In many countries, the pandemic is now spreading from urban to rural areas and between rural areas and is affecting economic and agricultural production.

Objective

8.25. The objectives are:

(a) To prevent, reduce the spread of and minimize the impact of HIV infection. To increase awareness of the disastrous consequences of HIV infection and AIDS and associated fatal diseases, at the individual, community and national levels, and of the ways of preventing it. To address the social, economic, gender and racial inequities that increase vulnerability to the disease;

(b) To ensure that HIV-infected individuals have adequate medical care and are not discriminated against. To provide counselling and other support for people infected with HIV and to alleviate the suffering of people living with AIDS and that of their family members, especially orphans. To ensure that the individual rights and the confidentiality of persons infected with HIV are respected. To ensure that sexual and reproductive health programmes address HIV infection and AIDS;

(c) To intensify research on methods to control the HIV/AIDS pandemic and to find an effective treatment for the disease.

Actions

8.26. Governments should assess the demographic and development impact of HIV infection and AIDS. The AIDS pandemic should be controlled through a multisectoral approach that pays sufficient attention to its socio-economic ramifications, including the heavy burden on health infrastructure and household income, its negative impact on the labour force and productivity, and the increasing number of orphaned children. Multisectoral national plans and strategies to deal with AIDS should be integrated into population and development strategies. The socio-economic factors underlying the spread of HIV infection should be investigated, and programmes to address the problems faced by those left orphaned by the AIDS pandemic should be developed.

8.27. Programmes to reduce the spread of HIV infection should give high priority to information, education and communication campaigns to raise awareness and emphasize behavioural change. Sex education and information should be provided to both those infected and those not infected, and especially to adolescents. Health providers, including family planning providers, need training in counselling on sexually transmitted diseases and HIV infection, including the assessment and identification of high-risk behaviours needing special attention and services; training in the promotion of safe and responsible sexual behaviour, including voluntary abstinence and [condom use]; training in the avoidance of contaminated equipment and blood products; and in the avoidance of sharing needles among intravenous drug users. Governments should develop guidelines and counselling services on AIDS and sexually transmitted diseases within the primary health care services. Wherever possible, reproductive health programmes, including family planning programmes, should include facilities for the diagnosis and treatment of common sexually transmitted diseases, including reproductive tract infection, recognizing that many sexually transmitted diseases increase the risk of HIV transmission. The links between the prevention of HIV infection and the prevention and treatment of tuberculosis should be assured.

8.28. Governments should mobilize all segments of society to control the AIDS pandemic, including non-governmental organizations, community organizations, religious leaders, the private sector, the media, schools and health facilities. Mobilization at the family and community levels should be given priority. Communities need to develop strategies that respond to local perceptions of the priority accorded to health issues associated with the spread of HIV and sexually transmitted diseases.

8.28 bis. The international community should mobilize the human and financial resources required to reduce the rate of transmission of HIV infection. To that end, research on a broad range of approaches to prevent HIV transmission and to seek a cure for the disease should be promoted and supported by all countries. In particular, donor and research communities should support and strengthen current efforts to find a vaccine and to develop women-controlled methods, such as spermicides with microbicidal effects, to prevent HIV infection. Increased support is also needed for the treatment and care of HIV-infected persons and AIDS patients. The coordination of activities to combat the AIDS pandemic must be enhanced. Particular attention should be given to activities of the United Nations system at the national level, where measures such as joint programmes can improve coordination and ensure a more efficient use of scarce resources. The international community should also mobilize its efforts in monitoring and evaluating the results of various efforts to search for new strategies.

8.28 ter. Governments should develop policies and guidelines to protect the individual rights of and eliminate discrimination against persons infected with HIV and their families. Services to detect HIV infection should be strengthened, making sure that they ensure confidentiality. Special programmes should be devised to provide care and the necessary emotional support to men and women affected by AIDS and to counsel their families and near relations.

8.29. Responsible sexual behaviour, [in particular/including] voluntary sexual abstinence, for the prevention of HIV infection should be promoted and included in education and information programmes. Condoms and drugs for the treatment of sexually transmitted diseases should be made widely available and affordable and should be included in all essential drug lists. Effective action should be taken to further control the quality of blood products and equipment decontamination.